HOUSE BILL 2205
By Shepard

SENATE BILL 1675

By Herron

AN ACT to amend Tennessee Code Annotated, Title 39; Title 56 and Title 71, relative to fraud involving medical assistance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 25, is amended by adding the following as a new section:

71-5-2522.

(a) If upon prosecution of any case for Medicaid fraud by a district attorney general based upon information and evidence provided by the office, a court awards restitution or civil forfeiture, the following portions of the non-federal share of the moneys derived therefrom shall be allocated as follows:

(1) Twenty percent (20%) thereof shall be allocated to the county in which such prosecution was commenced and shall be deposited by such county into a special fund in the county treasury. The moneys in such special fund shall be expended by the office of the district attorney general solely for the purposes of the detection, investigation and prosecution of Medicaid fraud and other crimes against public revenue. Any moneys expended by the office of the district attorney general pursuant to this subsection shall supplement the annual county appropriation to such office, and under no circumstances shall the moneys derived pursuant to this subsection be used to replace or supplant the amount of moneys appropriated by the county to the office of the district attorney general during the prior fiscal year;

(2) Twenty percent (20%) thereof shall be allocated to the county in which such prosecution was commenced and shall be deposited in the general fund for

such county or city; provided, however, that, in any case in which the office determines that fraudulent Medicaid payments were attributable to Medicaid recipients residing outside such county or city, then the amount allocated pursuant to this subsection shall be divided among the counties in which such recipients reside in such proportion as shall be determined by the office. All moneys received pursuant to this subsection shall be deposited into the general fund of the county receiving such moneys; and

(3) Sixty percent (60%) thereof shall be allocated to the state for deposit by the state in accordance with Section 71-5-2520(a).

(b) If, based upon information and evidence developed by a county or city investigation or a district attorney, the office or the department of law enters into a civil settlement of a case of suspected Medicaid fraud the following portions of the non-federal share of the proceeds of such settlement shall be allocated as follows:

(1) Fifteen percent (15%) thereof shall be allocated to the county in which the county or city investigation or district attorney general providing such information and evidence is located and shall be deposited by such county or city into a special fund in the county or city treasury. The moneys in such special fund shall be expended by the office of the district attorney general solely for the purposes of the detection, investigation and prosecution of Medicaid fraud and other crimes against public revenue. Any moneys expended by the office of the district attorney general pursuant to this paragraph shall supplement the annual local appropriation to such office, and under no circumstances shall the moneys derived pursuant to this subsection be used to replace or supplant the amount of moneys appropriated by the county or city to the office of the district attorney general during the prior fiscal year;

(2) Fifteen percent (15%) thereof shall be allocated to the county or city in which the county or city investigation or district attorney general providing such information and evidence is located and shall be deposited into the general fund for such county or city; provided however, that, in any case in which the office determines that fraudulent Medicaid payments were attributable to Medicaid recipients residing outside such county or city, then the amount allocated pursuant to this paragraph shall be divided among the counties and cities in which such recipients reside in such proportion as shall be determined by the department. All moneys received pursuant to this paragraph shall be deposited in the general fund of the city or county receiving such moneys; and

(3) Seventy percent (70%) thereof shall be allocated to the state for deposit in accordance with Section 71-5-2520(a).

SECTION 2. Tennessee Code Annotated, Title 71, Chapter 5, Part 26, is amended by adding the following as a new section.

71-5-2605.

(a) No person knowingly shall:

(1) Solicit, receive, accept or agree to receive or accept any payment or consideration in any form from another person to the extent such payment or other consideration is given to induce such person to engage in or refrain from engaging in:

(A) The referral of an individual to that person for the furnishing or arranging for the furnishing of any item or services in connection with a health plan; or

(B) The purchase, lease or order, or recommendation or arrangement to purchase, lease or order, any good, facility, service or item in connection with a health plan; or

(2) Offer, agree to give or give any payment or other consideration in any form to another person to the extent such payment or other consideration is given to induce such person to engage in or refrain from engaging in:

(A) The referral of an individual to that person for the furnishing or arranging for the furnishing or any item or services in connection with a health plan; or

(B) The purchase, lease or order, or recommendation or in connection with a health plan.

(b) As used in this section, "health plan" means any plan or contract funded through the state's medical assistance (Medicaid) program under which any medical benefit item or service is provided to any individual and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract.

(c) Subsection (a) of this section shall not apply to any activity specifically exempt under the federal anti-kickback statute, 42 U.S.C. § 1320a-7b, as from time to time amended, or by any other federal statute or regulation promulgated thereunder.

(d) Any person who violates the provisions of this section is guilty of a misdemeanor punishable by:

(1) A term of imprisonment in accordance with a Class A misdemeanor; or

(2) A fine of not less than five hundred dollars ($500) nor more than ten thousand dollars ($10,000); or

(3) If the defendant has obtained money or property through a violation of the provisions of this section, a fine in an amount, fixed by the court, not to exceed double the amount of the defendant's gain from a violation of such provisions; or

(4) Both the imprisonment and the fine.

(e) Any person who violates the provisions of this section and thereby obtains money or property having a value in excess of seven thousand five hundred dollars ($7,500) shall be guilty of a Class E felony.

SECTION 3. Tennessee Code Annotated, Title 71, Chapter 5, Part 26, is amended by adding the following as a new section:

71-5-2606.

(a)

(1) A person is guilty of making false statements relating to health care in the second degree when, in any matter related to a health plan, he or she, in connection with the provision of health care or related services, knowingly:

(A) Falsifies, conceals, or omits by an trick, scheme, artifice, or device a material fact; or

(B) Makes or uses any false, fictitious, or fraudulent statements or representations; or

(C) Makes or uses any false writing or document, knowing the same to contain any false, fictitious, or fraudulent statement or entry.

(2) Making false statements relating to health care in the second degree is a Class A misdemeanor.

(b)

(1) A person is guilty of making false statements relating to health care in the first degree when he or she commits the crime of making false statements relating to health care in the second degree with intent to commit another crime or to aid or conceal the commission thereof.

(2) Making false statements relating to health care in the first degree is a Class E felony.

SECTION 4. Tennessee Code Annotated, Title 71, Chapter 5, Part 26, is amended by adding the following as a new section:

71-5-2607.

(a)

(1) A person is guilty of possession of criminally diverted prescription medications and devices in the fourth degree when he or she knowingly possesses a prescription medication or device with knowledge that such medication or device was transferred or delivered as the result of a theft or under circumstances evincing an intent to engage in a theft.

(2) Possession of criminally diverted prescription medications and devices in the fourth degree is a Class A misdemeanor.

(b)

(1) A person is guilty of possession of criminally diverted prescription medications and devices in the third degree when he or she commits the crime of possession of criminally diverted prescription medications and devices in the fourth degree and:

(A) Has previously been convicted of any crime defined in this part; or

(B) The total pecuniary value of the prescription medications or devices possessed is in excess of one thousand dollars ($1,000).

(2) Possession of criminally diverted prescription medications and devices in the third degree is a Class E felony.

(c)

(1) A person is guilty of possession of criminally diverted prescription medications and devices in the second degree when he or she commits the crime of possession of criminally diverted prescription medications and devices in the fourth degree and the total pecuniary value of the prescription medications or devices possessed is in excess of three thousand dollars ($3,000).

(2) Possession of criminally diverted prescription medications and devices in the second degree is a Class D felony.

(d)

(1) A person is guilty of possession of criminally diverted prescription medications and devices in the first degree when he or she commits the crime of possession of criminally diverted prescription medications and devices in the fourth degree and the total pecuniary value of the prescription medications or devices possessed is in excess of fifty thousand dollars ($50,000).

(2) Possession of criminally diverted prescription medications and devices in the first degree is a Class C felony.

(e) Possession of false, forged or stolen prescriptions by any person other than a person in the lawful pursuit of his or her profession shall be presumptive evidence of the intent to use such prescriptions to commit a criminal act under this part.

SECTION 5. Tennessee Code Annotated, Title 71, Chapter 5, Part 26, is amended by adding the following as a new section:

71-5-2608.

(a)

(1) The general assembly finds that medical assistance (Medicaid) providers may be able to detect and correct payment and billing mistakes and fraud if required to develop and implement corporate compliance programs. It is the purpose of such programs to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences. The general assembly accordingly declares that it is in the public interest that providers of medical assistance implement compliance programs.

(2) The general assembly also recognizes the wide variety of provider types in the medical assistance programs and the need for compliance programs to be scalable according to a provider's size, complexity, resources, and culture. For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics. At the same time, however, the general assembly determines that there are key components that must be included in every compliance program and such components should be required if a provider is to be a medical assistance program participant. Accordingly, the provisions of this section require providers' adoption of effective corporate compliance program elements and making each provider responsible for implementing such a program appropriate to its characteristics.

(b) Pursuant to subdivision (d)(1) of this section, every provider of medical assistance items and services shall adopt and implement a corporate compliance program. Such program shall at a minimum be applicable to billings to and payments

from the medical assistance program but need not be confined to such matters. The corporate compliance program required pursuant to this section may be a component of more comprehensive compliance activities by the medical assistance provider so long as the requirements of this section are met. A corporate compliance program shall include the following elements:

(1) Written policies and procedures that describe compliance expectations as embodied in a corporate code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(2) Designate a corporate position vested with responsibility for the day-to-day operation of the compliance program; such position's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such position shall directly report to the entity's chief executive and shall periodically report directly to the governing body on the activities of the compliance program;

(3) Training and education of all employees, appointed staff and others associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of new employee, appointee or associate, executive and governing body member orientation;

(4) Communication lines to the responsible corporate compliance position, as described in subdivision (b)(1), accessible to all employees, persons associated with the provider, executives and governing body members, to allow

compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(5) Disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, such policies to articulate expectations for reporting compliance issues, assisting in their resolution and sanctions for failure to report known problems, participation in non-compliant behavior or encouragement of non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;

(6) A system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits;

(7) A system for responding to compliance issues as they are raised; for investigating potential compliance problems; for responding to compliance problems as identified in the course of self-evaluations and audits; for correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; and for reporting compliance issues to government officials appropriate to the seriousness of the subject compliance matter; and

(8) A policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as otherwise provided by law.

(c) The bureau of TennCare shall have the authority to determine if a provider has a compliance program that satisfactorily meets the requirements of this section.

(1) In the event the bureau of TennCare finds that the provider does not have such a program and so notifies the provider, the provider shall promptly develop and implement a program satisfactory to the bureau.

(2) If the provider does not implement a satisfactory program within the time specified by the bureau of TennCare in its notice, but in no event less than sixty (60) days, the bureau may impose the penalties as authorized by this chapter. In addition, the bureau may revoke the provider's agreement to participate in the medical assistance program and shall take such steps as are necessary to effect the provider's withdrawal from the medical assistance program with minimal disruption to medical assistance recipients' care, safety and welfare.

(d)

(1) Not later than six (6) months after the effective date of this section, the bureau of TennCare shall promulgate regulations establishing those providers that shall be subject to the provisions of this section.

(2) Notwithstanding subdivision (1) of this section, the provisions of this section are self-implementing and no agency, department or bureau shall have the authority to develop or implement any rules or regulations imposing any requirements for satisfactory compliance program content other than those expressly provided in this section. The foregoing shall not be deemed to prevent the bureau from providing guidance or educational information in response to inquiries from medical assistance providers.

SECTION 6. Tennessee Code Annotated, Title 71, Chapter 5, Part 26, is amended by adding the following as a new section:

71-5-2609.

(a) The office of inspector general, established by part 25 of this chapter, shall develop and implement protocols to allow a medical assistance provider to disclose and make restitution of medical assistance payments that the provider has received and the provider in good faith believes are incorrect due to mistaken or erroneous billing by the provider, mistaken or erroneous payment by the bureau of TennCare, incorrect rate calculation by the bureau of TennCare, a violation of state criminal or civil law or due to another reason identified by the provider.

(b) In developing such protocols, the office of inspector general shall consult with the bureau of TennCare, the attorney general and reporter, the Tennessee bureau of investigation, the comptroller and providers of medical assistance.

(c) Such protocols shall provide that:

(1) The provider shall submit the disclosure in writing, identifying itself and an authorized contact person;

(2) The subject matter of the disclosure is described in sufficient detail to allow the Inspector general and the bureau of TennCare to clearly identify the matter being disclosed;

(3) There is a description of the provider's actions taken to discover, investigate and audit the matter and disclosure of the individuals involved, by title;

(4) There is a statement of the duration of the incorrect medical assistance payments, whether the incorrect payments are occurring as of the

date of the disclosure, the total amount incorrectly paid as of an identified date and the provider method of calculating such total;

(5) There is a statement of actions the provider has taken or will take to prevent recurrences of the same mistaken payments or to notify the office when it detects mistaken payments or rate calculations; and

(6) There is a statement of other preventive measures the provider has taken or will take to reduce the incidence of future similar incorrect medical assistance payments.

(d)

(1) The office of inspector general shall review the disclosure submitted by the provider and determine whether:

(A) The provisions of subsection (c) of this section have been met;

(B) The provider's submission is complete and accurate; and

(C) The use, if any, of statistical sampling techniques is satisfactory to the office using generally acceptable statistical sampling methods and standards.

(2) If, in the discretion of the office of inspector general, the conditions set forth in subdivision (1) are not satisfied, it shall notify the provider in writing, disclose any deficiencies and afford the provider an opportunity to resubmit information. The office of inspector general shall work in good faith to assist the provider to accurately complete and resolve any issues related to the submission. Upon any resubmission, the office of inspector general shall review the matter and take action as provided in this subsection.

(3) If, in the discretion of the office of inspector general, the conditions set forth in subdivision (1) are satisfied, it shall so notify the provider. The notice

shall include the amount the provider shall pay in restitution, which shall equal the amount of incorrectly overpaid medical assistance funds, plus the interest accrued thereon and any other information the department deems appropriate. Interest shall accrue at the then-current prime lending rate as set by the federal reserve board.

(4) The office of inspector general shall take all necessary actions to prevent further incorrect payments to the provider regarding the subject matter of the disclosure.

(5) If, at the time of the submission of the disclosure, the provider did not know or could not reasonably have known of the commencement of an investigation or proceeding regarding the subject matter of the disclosure and the provider has made complete restitution, including execution and performance of a repayment agreement with the office of inspector general, plus any accrued interest as set forth in subdivision (c)(4) of this section, the provider shall be immune from further administrative or civil liability, including charges of unprofessional practices, regarding the incorrect medical assistance payments that are the subject matter of the disclosure. Nothing in this subdivision shall be deemed to impair or interfere with the office of inspector general's authority to investigate any matter, or refer such matter, for criminal investigation and prosecution and nothing in this subdivision shall be deemed to interfere with the prosecution of alleged criminal activity.

SECTION 7. Tennessee Code Annotated, Title 71, Chapter 5, Part 26, is amended by adding the following as a new section:

71-5-2610.

(a) If a provider of medical assistance items or services submits a written request, including an electronic submission, to the bureau of TennCare seeking guidance regarding the furnishing of medical assistance items or services or submission of claims for payment for items or services, the bureau shall provide such guidance in writing, which may be transmitted electronically, within sixty (60) days of receipt of such request.

(b) If:

(1) In its request, the provider accurately presented the circumstances relating to such items or services or claims;

(2) The provider in reasonable reliance followed the written guidance provided by the bureau of TennCare pursuant to subsection (a) of this section; and

(3) The guidance provided by the bureau of TennCare is determined by such department or any other state agency, or the attorney general to be erroneous, then the provisions of subsection (c) of this section shall apply.

(c) If the conditions in subsection (b) of this section are met, the provider shall not be subject to any administrative or civil penalty, interest or multiple damages of any kind, including administrative sanctions, with respect to the items or services or claims for payment which were the subject of the request.

(d) Nothing in this section shall be construed as preventing the recoupment or repayment of the amount of an overpayment, without interest, penalty or multiple damages, insofar as the overpayment was solely the result of a clerical or technical operational error. If the provisions of subsection (b) of this section are met, then the recoupment provided for by this subdivision shall be limited to the actual amount of overpayments made, without interest, penalty or multiple damages.

SECTION 8. Tennessee Code Annotated, Title 71, Chapter 5, Part 26, is amended by adding the following as a new section:

(a) The bureau of TennCare shall develop, test and implement new methods to strengthen the capability of the Medicaid payment information system to detect and control fraud and improve expenditure accountability, and is hereby authorized to enter into further agreements with fiscal and/or information technology agents for the development, testing and implementation of such new methods. Any such agreements shall be with agents which have demonstrated expertise in the areas addressed by the agreement.

(b) Such methods, shall, at a minimum, address the following areas:

(1) The bureau of TennCare, in consultation with contracted participating managed care organizations, shall develop, test and implement an automated claims review process which, prior to payment, shall subject Medicaid services claims to review for proper coding. The bureau of TennCare shall designate which services shall be subject to review based on: the expected cost-effectiveness of reviewing such service; the capabilities of the automated system for conducting such a review; and the potential to implement such review with negligible effect on the turnaround of claims for provider payment or on recipient access to necessary services. Such initiative shall be designed to provide for the efficient and effective operation of the Medicaid claims payment system by performing functions including, but not limited to, capturing coding errors and misjudgments, such as incorrect or multiple billing for the same service, possible excesses in billing or service use, such as a recipient's repeated reliance on emergency rooms for non-emergency services.

(2) The bureau of TennCare, in consultation with contracted participating managed care organizations, shall develop, test and implement an automated process to improve the coordination of benefits between the medical assistance program and other sources of coverage for medical assistance recipients. Such initiative shall initially examine the savings potential to the medical assistance program through retrospective review of claims paid which shall be completed not later than October 30, 2008. If, based upon such initial experience, the bureau of TennCare deems the automated process to be capable of including or moving to a prospective review, with negligible effect on the turnaround of claims for provider payment or on recipient access to services, then the bureau of TennCare shall in subsequent tests examine the savings potential through prospective, pre-claims payment review which shall be completed not later than March 1, 2009.

(3) The bureau of TennCare shall take all reasonable and necessary actions to intensify the state's current level of monitoring, analyzing, reporting and responding to medical assistance claims data maintained by the state's Medicaid management information system contract agents. Pursuant to this initiative, the bureau of TennCare shall seek to improve the utilization of such data in order to better identify fraud and abuse within the medical assistance program and to identify and implement further program and patient care reforms for the improvement of such program. In addition, the bureau of TennCare, in consultation with such contract agents, shall identify additional data elements that are maintained and otherwise accessible by the state, directly or through any of its contractors, that would, if coordinated with medical assistance data, further increase the effectiveness of data analysis for the management of the medical

assistance program. To further the objectives of this subdivision, the bureau of TennCare shall provide or arrange in-service training for state medical assistance personnel to increase the capability for data analysis, leading to a more cost-effective operation of the medical assistance program.

(4) The bureau of TennCare shall develop, test and implement an automated process for the targeted review of claims, services and/or populations not later than October 30, 2008. Such review shall be for the purposes of identifying statistical aberrations in the use or billing of such services and for assisting in the development and implementation of measures to ensure that service use and billing are appropriate to recipients' needs. Such review shall not be conducted for the purposes of retrospective payment denial but may be used for improved guidance to providers, for system revision and for recipient health service management.

(c) The commissioner of finance and administration shall prepare and submit an interim report to the governor and general assembly on the implementation of the initiatives specified in subsections (a) and (b) by no later than December 1, 2008. Such report shall also include recommendations for any revisions which would further facilitate the goals of such section, including recommendations for expansion. The commissioner shall submit a final report not later than December 1, 2009. In preparing such interim and final reports, the commissioner shall consult with third-party agents, providers and recipients associated with the implementation of subsections (a) and (b).

SECTION 9. The commissioner of finance and administration is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 10. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 11. This act shall take effect July 1, 2007, the public welfare requiring it.